Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: July 19, 2024

Inspection Number: 2024-1321-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Fountain View Community, Toronto

Lead Inspector	**Inspector Digital Signature**
Ann McGregor (000704)	Ann McGregor Digitally signed by Ann McGregor Date: 2024.08.21 15:20:04 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 17, 21, 24 - 25, 27- 28 and July 2 - 4 and 8 - 9, 2024

The inspection occurred off site on the following dates: July 4 and 9, 2024

The following intakes were inspected in this inspection:

- Intake: #00109635 - Follow-up #1 - CO #001 related to plan of care
- Intake: #00115834 - [CI: 2836-000008-24] - related to a fall of a resident resulting in injury
- Intake: #00117385 - [CI: 2836-000010-24] - related to a disease outbreak

The following complaint intakes were inspected in this inspection:

- Intake: #00114632 - related to a fall, foot care, housekeeping and resident transporting residents
- Intake: #00116925 - related to plan of care with meal services, pain management and skin and wound care

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1321-0006 related to FLTCA, 2021, s. 6 (4) (b) inspected by the inspector.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a Personal Support Worker (PSW) utilized safe transferring techniques for the resident following their fall.

Rationale and Summary:
A Critical Incident Systems (CIS) report was submitted related to an unwitnessed fall of a resident who sustained an injury. The PSWs improperly transferred the resident following their fall.

The Falls Lead confirmed that the PSWs did not follow the home's Zero Lift & Protocol policy with regards to safely transferring the resident after their fall.

Failure to use appropriate transfer techniques after the resident sustained a fall may have led to an increased risk of further complications to the resident's injury.

Sources: Home's policy titled, "Zero Lift & Protocol," dated April, 2005; Home's investigation notes, Interviews with PSWs, and Falls Lead.

COMPLIANCE ORDER CO #001 Plan of care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Complete daily audits for a minimum of 2 weeks or until 100% compliance for the following:
    1. That resident plan of care related to one-on-one monitoring is followed, if applicable.
    2. That fall prevention interventions are in place as required by the plan of care for the resident.
2. Keep written record of the auditing tool, including who competed the audit and document results of the audit, any concerns identified, and steps taken to resolve concerns.
3. Educate all staff who provide care to residents on the care plan interventions related to ensuring that if the resident requires one to one monitoring, that there is no gap between shifts.
4. Educate all staff who provide care to residents ensure that all fall prevention strategies are implemented.
5. Keep written record of the date/s the training for step 3, 4, and 5, names of staff who received training, and contents of the training.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to the residents as specified in their plan.

Rationale and Summary

i) The resident's plan of care specified that the resident was to receive one-to-one monitoring. On a particular day, the PSW left the resident unattended prior to the arrival of the oncoming PSW. The resident experienced a fall while unattended.

Interview with the PSW confirmed that they left the resident unattended prior to the arrival of the oncoming PSW.

Failure of staff providing the resident with one-to-one monitoring minimized the effectiveness of the resident's plan of care interventions.

Sources: Resident's plan of care, and interviews with PSW, RN, and the DOC.

Rationale and Summary

ii) The resident's plan of care specified that the resident was to have specific fall interventions in place.

The inspector observed that the resident did not have their fall prevention in place.

Interview with the RN confirmed that the resident required fall prevention.

There was risk of injury to the resident when staff did not follow the resident's plan of care.

Sources: Observation of resident, resident's clinical health records, and interviews with PSW, RN and Falls Lead.

This order must be complied with by August 30, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Educate all PSW and RPN staff on a specified home area on supporting hand hygiene for residents prior to meals.
2. Keep a written record of the education provided, the dates the training occurred, the names of the staff members who attended, and the name of the person who provided the training.
3. The IPAC Lead or designated registered nurse will complete hand hygiene audits during different meal services, three times a week for four weeks in the specified home area. Documentation of the audit must include the name of the person completing the audit, the meal service time, position, whether the resident hand hygiene was performed correctly, or missed, and any corrective actions taken, on-the-spot re-education provided, if necessary.
4. RPNs must be educated on the four moments of hand hygiene.
5. Educate all staff on the specified home area to ensure that Public Health measures that are in place are followed and how to verify if measures are no longer required.
6. Keep a written record of the education provided for step 4 and 5, the dates the training occurred and the name of the person who provided the training.

Grounds

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

According to O. Reg 246/22 s. 102 (2) (b), the licensee shall implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes, revised September 2023, s. 10.2 (c) stated that the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals.

Rationale and Summary

i) During the meal service on a specific home area, it was observed that residents were not consistently supported in performing hand hygiene prior to being served meal options. The inspector observed residents entering the dining area, take their seats, and were immediately offered meals. No hand hygiene services were provided to the residents that entered the dining area.

The RN confirmed that staff are expected to assist residents with hand hygiene prior to meal services.

Failing to support residents in the performance of hand hygiene prior to meals placed the residents at increased risk of exposure to infectious agents.

Sources: Observations of the inspector, interviews with RN and DOC.

ii) In accordance with additional requirement 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022) requires that routine practices were to be followed in the IPAC program, specifically hand hygiene, including, but not limited to, before aseptic procedures, before initial resident/resident environment contact and after resident/resident environment contact.

Rationale and Summary

A RPN was observed leaving a resident's room with PPE on. The RPN removed their PPE after leaving the resident's room, discarded them and immediately entered the dining room. The RPN did not perform hand hygiene.

Shortly after, the same nurse was observed walking down the hallway with PPE on. The nurse was then observed touching their nose and mouth with their PPE on, then entered a resident's room, completed treatment, and did not change their PPE or performed hand hygiene.

Interview with the RPN confirmed that they did not perform hand hygiene after removing their PPE, upon entering a resident's room and prior to proving treatment.

Failure for staff to complete hand hygiene at the required moments of hand hygiene posed a risk of increased infectious disease transmission.

Sources: Observation of RPN, IPAC Standard (revised Sept 2023), Policy "Hand Hygiene" (April 2022), interviews with the IPAC Lead, DOC and RPN.

iii) In accordance with additional requirement 4.2 (e) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022), the licensee has failed to ensure that all staff always comply with applicable masking requirements, specifically regarding universal masking on the residents' home area during an outbreak.

Rationale and Summary

On numerous occasions, the inspector observed staff were not wearing masks on the unit during an outbreak.

Interviews with IPAC Lead and DOC confirmed that staff are expected to comply with IPAC measures and Public Health instructions during an outbreak.

There was risk of infection transmission to residents when staff do not follow Public Health guidelines.

Sources: Observation by Inspector, Public Health instructions, IPAC Standard for Long-Term Care Homes (April 2022) and interview with IPAC Lead and DOC.

This order must be complied with by August 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.